319 CYE 16 AND CYE 17 – CHILDREN'S REHABILITATIVE SERVICES VALUE-BASED PURCHASING INITIATIVE

EFFECTIVE DATE: 10/01/15

REVISION DATES: 06/11/15, 07/06/17

I. PURPOSE

This Value-Based Purchasing (VBP) Initiative Policy applies to the Children's Rehabilitative Services (CRS) Contractor. This Policy applies to dates of service effective on and after October 1, 2015. The purpose of this initiative is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the Contractor and provider through VBP strategies.

II. DEFINITIONS

ENCOUNTER

For the purposes of this policy, all encounters must be in an adjudicated and approved status.

PERFORMANCE BASED PAYMENT

A payment from a Contractor to a provider upon successful completion or expectation of successful completion of contracted goals/measures in accordance with the VBP strategy selected for the contract. This is a non-encounterable payment and does not reflect payment for a direct medical service to a member. This payment will typically occur after the completion of the contract period, but could include quarterly or semi-annual payments if contract terms specify such payments in recognition of successful performance measurement.

VALUE-BASED PURCHASING STRATEGIES

A model which aligns payment more directly to the quality and efficiency of care provided by rewarding providers for their measured performance across the dimensions of quality.

VBP strategies for this initiative may include any combination of Primary Care Incentives (PC), Performance-Based Contracts (PB), Bundled/Episode Payments (BE), Shared Savings (SS), Shared Risk (SR) and Capitation + Performance-Based Contracts (CP) purchasing strategies as defined below, in order from least to greatest provider financial risk. See Attachment A to view the continuum of VBP strategies.

FEE-FOR-SERVICE

Purchasing strategy in which providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency.

This strategy shall not be counted towards the minimum qualifying criteria outlined under C.1.

PRIMARY CARE INCENTIVES

Purchasing strategy in which providers/physicians are rewarded with bonus payments for meeting certain performance measures for quality and/or cost. It can also include disincentives, such as eliminating payments for negative consequences of care (i.e. medical errors) or for increased costs and is typically paid in addition to fee-for-service payments. Also known as Pay for Performance or P4P.

PERFORMANCE-BASED CONTRACTS

Purchasing strategy in which a portion of the provider's total potential payment is tied to a provider's performance on cost-efficiency and quality performance measures. While providers may still be paid fee-for-service for a portion of their payments, they may also be paid a bonus or have payments withheld. The bonus is not paid unless the provider meets cost-efficiency and/or quality targets.

BUNDLED/EPISODE PAYMENTS

Purchasing strategy in which the provider is reimbursed on the basis of expected costs for clinically defined episodes that may involve several practitioner types, several settings of care and several services or procedures over time. The provider receives a lump sum for all health services delivered for a single episode of care. An example is payment to obstetricians for the ongoing management of pregnancy, delivery and postpartum care.

SHARED SAVINGS

Purchasing strategy which provides an incentive for providers or provider entities to reduce unnecessary health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings (e.g. upside risk only). "Savings" can be measured as the difference between expected and actual cost in a given contract year, for example. Shared savings programs can be based on a fee-for-service purchasing system. Shared savings can be applied to some or all of the services that are expected to be used by a patient population and vary based on provider performance.

SHARED RISK	Purchasing strategy in which payer and provider share upside and downside risk against an agreed-upon budget after meeting quality and experience thresholds. Refers to arrangements in which providers accept some financial liability for not meeting specified financial or quality targets. Examples include loss of bonus; baseline revenue loss; or loss for costs exceeding global or capitation payments; withholds that are retained and adjustments to fee schedules. For the purposes of data collection, shared risk programs that include shared savings should only be included in the shared risk category (e.g. includes both upside and downside risk). Shared risk programs can be based on a fee-for-service purchasing system.
CAPITATION + PERFORMANCE-BASED CONTRACTS	Purchasing strategy in which a provider or group of providers are reimbursed a set amount for each enrolled person assigned to them, rather than paying providers for individual services. Providers or groups of providers are expected to assume a certain level of financial risk under a capitated payment system. The provider is responsible for the quality, cost and experience outcomes of specific population of patients and receives payments based on per member per month, rather than fee-for-service. To be considered as a value based purchasing strategy, payment adjustments must be made based on measured performance and patient risk. It is intended to promote efficient and high quality care and coordination among providers for population health management.

III. POLICY

A. GENERAL

The Contractor must meet the VBP strategies qualifying criteria in C.1., and certify as described in C.2. Failure to meet or certify to meeting the criteria in a particular contract year will result in sanctions up to a maximum of $250,000.

B. AHCCCS RESPONSIBILITIES

1. The performance based payments will be added to the reconciliation calculated in accordance with ACOM Policy 312 CYE 14 and Forward as follows:

   For dates of service from October 1, 2015 through September 30, 2016 the performance based payments total will be added to the total of the CYE16 final reconciliation receivable or payable. For dates of service from October 1, 2016 through September 30, 2017 the performance based payments total will be added to the total of the CYE17 final reconciliation receivable or payable. In either year, if the Contractor is within the risk corridor/band the total performance based payments will be an added payable for that year.

The Contractor shall report the performance based payments on an accrual basis. AHCCCS reserves the right to perform a look-back and true-up of the previous year's accrual in a subsequent year's reconciliation.

2. For any VBP contract that is effective for a period other than the measurement year, AHCCCS will allow performance based payments to be included in the appropriate years' reconciliations to which the payments are attributable. For example, a contract effective from April 1, 201X to March 31, 201Y will have six months (April 1, 201X – September 30, 201X) in the 201X reconciliation and six months (October 1, 201X – March 31, 201Y) in the 201Y reconciliation.

   The Contractor is not required to meet the VBP strategies qualifying criteria in C.1 in order for the performance-based payments to be added to the Contractor's CYE16 and forward reconciliations.

C. CONTRACTOR RESPONSIBILITIES

1. A minimum of 20 percent in CYE16 and 35 percent in CYE 17 of the value of total prospective payments, VBP and non-VBP, contracted and non-contracted, must be governed by VBP strategies for the contract year. AHCCCS intends that the minimum value threshold will grow each year according to the schedule below.

YEAR	INTENDED MINIMUM VALUE PERCENTAGE
CYE 18	50%
CYE 19	60%
CYE 20	70%
CYE 21	70%

   Strategies for this initiative may include any combination of the VBP strategies defined in Section II with the exception of the Fee-For-Service Strategy. Strategies utilized must meet the definitions provided under Section II. Strategies must be designed to achieve cost savings and quantifiable improved outcomes.

   A minimum of 25 percent of the percentage requirement noted above shall be with an organization that includes Primary Care Providers (PCPs).

   The Contractor shall be responsible for identifying which strategy applies to each VBP contract and whether each contract applies to a limited cost of care, where the provider can only impact direct and limited costs attributed to members, or the total cost of care attributed to members. For example, a contract with a transportation provider which rewards the provider for improvement in on-time pick-ups would count as a limited cost of care contract since the provider has no impact on the members' total medical costs and only directly affects transportation expense. Alternatively, a contract with a PCP which rewards the provider for reducing total medical expenses attributed to members, including those not directly provided by the PCP, would count as a total cost of care contract.

The same dollars shall not be counted under multiple contracts.

Additionally, one contract shall not be counted under multiple strategies.

In order to count towards meeting the qualifying criteria, strategies shall be evidenced by written contracts. For those contracts executed prior to February 1 of each measurement year, AHCCCS shall count the strategies for the time period in the contract year for which the contract is in effect. For CYE 16 and CYE17: For those contracts executed after February 1 of each measurement year, AHCCCS shall count the strategies for the time period from the execution date forward for which the contract is in effect.

2. The Contractor will certify to AHCCCS that these requirements will be met by submitting both an executed copy and an electronic copy in an Excel format and through the Structured Payment File described in Section D:
   a. An initial VBP strategies Certification as provided in Attachment B to the DHCM Finance Manager within 60 days of the start of the contract year, and
   b. A final VBP strategies Certification as provided in Attachment B to the DHCM Finance Manager and the Structured Payment File due 270 days after the end of the measurement year.

   In the case of differences between the executed copy and electronic template submissions, the executed copies will prevail.

   Failure to attest to the VBP strategies qualifying criteria in a particular contract year will result in sanctions up to a maximum of $250,000.

   AHCCCS reserves the right to request an audit of the Certifications included in Attachment B.

D. STRUCTURED PAYMENT FILE AND POST ADJUDICATED/POST SUBMITTED FILE

1. AHCCCS has developed a Structured Payment File to automate the VBP Strategies Certification excel file. The Contractor shall submit this file annually for CYE16 and CYE17. (See C.2.b.) For details on the file layout and FTP submission process, refer to the AHCCCS Structured Payment Transmission User Manual https://azahcccs.gov/Resources/Downloads/OperationsReporting/StructuredPaymentTransmissionCompanionGuide.pdf.

2. In order to link encounters to the Structured Payment File, the Contractor shall add a VBP Indicator to encounters paid under a VBP contract. Refer to the AHCCCS Technical Interface Guidelines (TIG) AHCCCS Technical Interface Guidelines (TIG) - Post Adjudicated Structured Payment File for information on the VBP Indicator. https://www.azahcccs.gov/Resources/Downloads/Contractor/Tables/PostAdjudicatedStructuredPaymentFileLayout.pdf.

   If the Contractor knows upfront that the encounter is tied to a member/provider under VBP contract, the Contractor should include the VBP Indicator in the original encounter submission.

If the Contractor does not know upfront that the encounter is tied to a member/provider under VBP contract, the Contractor shall add the VBP Indicator to the adjudicated encounter via the Post Adjudicated/Post Submitted File. The Contractor may choose to only use the post adjudication adjustment process to add the VBP Indicator to adjudicated encounters, if desired.

All applicable encounters should have the VBP Indicator included 270 days following the contract year end.